

MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

June 2003

DATA SYSTEMS & ANALYSIS

Data Base and Application Development

Release of the 2002 Long-term Care Survey

MHCC will release the 2002 Long-Term Care Survey in August 2003. Listed below is the release schedule.

Table 1 Major Milestones for 2002 LTC Survey

Notify Facilities of Survey	June 21, 2003
Mail Survey Instructions	July 18, 2003
Start of Survey	August 21, 2003
Last Day to Submit without Penalty	October 21, 2003

Facilities requested that the survey be released closer to the end of the calendar year. The release of the 2002 survey will occur approximately 2 months earlier than previous years. To meet the earlier deadline, MHCC staff has accelerated the revision and update activities. Despite a heavy workload, complicated by the state hiring freeze, the survey team has worked effectively to make the needed revisions and meet the August deadline.

Ambulatory Surgery Survey

The deadline for completing the 2002 survey in June has passed. Compliance based on survey tracking information as of June 10th is as follows:

Table 2 Final Reporting Status for the Ambulatory Care Survey

Total Surveyed:	305
Total Completed:	292
Filed extension request	8
Letters sent for Noncompliance:	5

Medical Care Data Base Submissions for 2001

The Board of Public Works approved the second option year in a five year contract with Social and Scientific Systems (SSS) that supports continued data collection for the Maryland Medical Care Database. Payers must submit data to the Commission by June 30, 2003. The list of payers required to submit is shown in Table 3.

The 2002 submission will mark the 7th year of data collection for the Medical Care Data Base and the last year of the MHCC's contract with Social and Scientific System. Over the next several months, the staff will be evaluating alternative approaches to collecting information. With the introduction of HIPAA transactions standards in 2003, members of the staff believe that

opportunities exist to gather this information in a more cost-effective manner. Future RFPs will require vendors to exploit those opportunities as well as identify other savings.

**Table 3: 2002 Medical Care Data Base
Payers Required to Submit Information on
Services and Prescription Drugs**

Aetna Life Insurance Company	Great-West Life & Annuity Ins. Co.
Aetna U.S. Healthcare, Inc.	Group Hospitalization & Medical Services,
Allianz Life Ins. Co. of North America	Kaiser Foundation Health Plan of the Mid-
American Republic Insurance Co.	MAMSI Life and Health Ins Co.
CareFirst Blue Choice, Inc.	Maryland Fidelity Insurance Co.
CareFirst of Maryland, Inc.	MD-Individual Practice Association, Inc.
Cigna Healthcare Mid-Atlantic, Inc.	Mega Life & Health Ins. Co.
Connecticut General Life Insurance Co.	New York Life Insurance Co.
Corporate Health Insurance Co.	Optimum Choice, Inc.
Coventry - Principal Health Care of DE,	PFL Life
Delmarva Health Plan, Inc.	PHN-HMO, Inc.
Educators Mutual Life Insurance Co.	State Farm Mutual Automobile Ins. Co.
Fortis Insurance Co.	Trustmark Insurance Co.
Free State Health Plan, Inc.	Wellpoint-(UNICARE Life & Health)
Golden Rule Insurance Co.	Union Labor Life Insurance Co.
Graphic Arts Benefit Corp	United Healthcare Insurance Co.
	United Healthcare of the Mid-Atlantic, Inc.

Internet-Based Re-Licensure Applications

MHCC staff continues to work with the staff of the Board of Physicians (formerly BPQA) in modifying their physician renewal application to reflect the changes mandated by SB 500. The Board plans to launch the new renewal application on July 1, 2003.

Cost and Quality Analysis

Drug Utilization Studies

MOU with University of Maryland School of Pharmacy

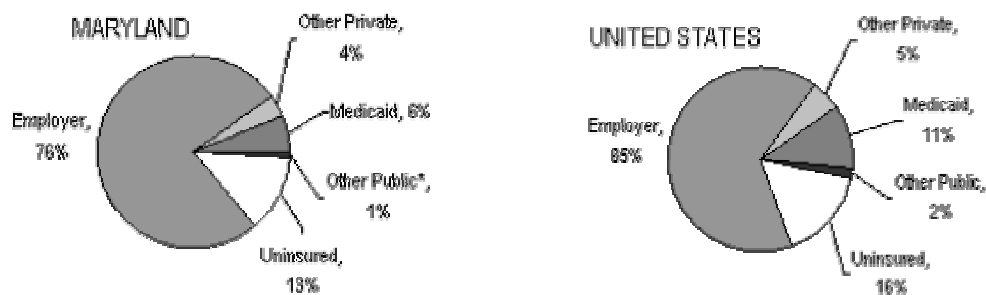
The Dr. Fadia Shaya from the University of Maryland School of Pharmacy will present her findings on changes out-of-pocket (OOP) spending for non-elderly Maryland residents with pharmacy coverage from 2000 to 2001 at the Commission's July meeting. This report will be useful as the Commission examines possible changes to the benefit package in the CSHBP this summer.

The staff has begun work with SSS in developing a consumer and research oriented web site that will present information on drug utilization, prescribing patterns, and comparative costs of different drugs. Staff plans to preview this information at the September meeting. SSS has considerable experience developing similar sites for the Agency for Health Research and Quality (AHRQ) including MEPSNET and HCUPNET, the web sites used to disseminate information on the Medical Expenditure Survey and the Hospital Cost and Utilization Project, respectively.

HRSA-related Activities

Staff presented some findings from an analysis of health insurance status in Maryland residents using the two most recent years of data from the Current Population Survey (CPS), CY2000-2001, to the Health Care Coverage Workgroup on June 5, 2003. Although the results of the complete analysis of the CPS will not be available until September, examples of some of the findings are being presented now because of the importance of the issue. The overall proportion of state residents who lacked insurance for most of the year was 11%. Because nearly all elderly residents are covered by Medicare, the uninsured rate among non-elderly residents was slightly higher, 13%, as shown in the charts below. The charts also compare the state to the US and show that the state's uninsured rate was below the national average due to a higher rate of enrollment in employer-based health insurance. This higher employer rate is driven by federal government employees, who accounted for 10% of non-elderly adult Maryland workers compared to just 3% nationwide. The uninsured rate among federal employees, 3%, is the lowest among all employment classes. (Private firm employees actually comprise a lower percentage of non-elderly adult workers in Maryland than in the US, 58% versus 63 %.)

Health Insurance Coverage of the Non-Elderly, 2000-2001



EDI and Payer Programs

Maryland Trauma Fund Implementation

Staff is working with HSCRC to begin implementation of Senate Bill 479, legislation that provides for expanded reimbursement for physicians that provide care in Maryland Trauma Centers. During May, the Commission held planning meetings with the Medicaid Administration and the Motor Vehicle Administration regarding implantation issues. A coordination meeting was also held with Maryland Institute for Emergency Medical Services Systems (MIEMSS). The staff is moving ahead with plans to have proposed regulations before the Commission in July. Because a framework is needed immediately, staff will likely ask the Commission to approve emergency regulations and promulgate proposed regulations at the July meeting. Table 4 presents the implementation timeline for the funding.

Table 4 – Implementation Time for Senate Bill 479 Funding for Physicians Providing Trauma Care

May – June: Organizational Meetings with Trauma Physicians, Medicaid, MIEMSS, MVA
July – September: Promulgate Regulations, MVA Starts Fee Collection on Automobile Registration and Renewal
October – November: Medicaid Implementation; Align with October HIPAA Transaction Implementation
December: MHCC and HSCRC approve regulations, begin uncompensated care reporting, begin making on-call payments
Post January 2004: Full Implementation

EHN Certification

Passport Health has been approved for MHCC EHN Candidacy status. Staff reviewed the certification documentation from MetroData, a clearinghouse in MHCC EHN candidacy status. It was determined that this organization would not be able to meet the EHNAC and MHCC criteria for certification and MetroData was removed from candidacy status. MHCC staff provided ongoing consultative support to the SSI Group, considered as the third largest claims clearinghouse in the nation. The SSI Group is evaluating EHNAC accreditation and MHCC certification. This process had been continuing for nearly 13 months. Staff also provided support to Affiliated Network, an electronic health network, in completing their EHNAC and MHCC self-assessment documentation. This is Affiliated Network's first accreditation and certification renewal.

EDI Progress Report

The EDI Progress report for 2002 is due on June 30, 2003. As of June 12, 2003, MHCC received 9 of 45 2003 EDI Progress Reports from payers. Many of the remaining payers are working to complete the report prior to the deadline, with approximately 15 payers contacting the staff regarding items in the Report.

EDI Promotion and HIPAA Awareness

The EDI-HIPAA Workgroup met in early June to complete the development of the "Transactions Standards & Code Sets: A Practice Management Assessment Guide for Medical Offices." This tool is in the process of being posted on the MHCC website.

Over the last month staff members continued to provide support to health care organizations in their administration of the HIPAA privacy, security, and transaction standards. Inquiries regarding the privacy regulations that became effective April 14th remain high.

- Staff fielded approximately 8 HIPAA-related telephone calls per day.
- Presented on the privacy regulations to the medical staff at St. Mary's Hospital. Roughly 30 physicians attended the presentation.
- Assisted Sinai Hospital in developing a HIPAA consultant selection criterion for providing long-term training and education.
- Worked with the Maryland State Chiropractic Association to further develop MHCC's HIPAA education session at its summer conference.
- Provided consultative support to the Maryland Podiatric Association on a variety of HIPAA compliance issues.
- Beta tested the Professional Claims Required Data Element User Education Guide with Atlantic General Hospital.

- Presented on the privacy regulations to mental health workers in Salisbury. Approximately 60 mental health workers attended the presentation.
- Provided support to MedChi in defining MHCC's role at its annual summer conference. MedChi is looking for MHCC to provide its members with education on HIPAA's transactions and security regulations.
- Worked with the Maryland Optometrist Association's Executive Director to define MHCC's role at its fall conference.
- Worked with the Allegany Dental Association in developing a HIPAA privacy and transaction standards awareness session scheduled for late July.
- Reorganized the HIPAA, EDI and Medical Care Database sections of the MHCC website to provide easier user access and updated information.
- Presented on the transaction standards to Washington County Health Systems. About 55 people were in attendance.
- Worked with representatives from Robin Wood Medical Center to define MHCC's role at its late summer medical conference.
- Developed a newsletter relating to the upcoming transaction standards for publishing by various medical and non-medical health care associations.
- Convened 3 privacy question and answer sessions for office managers in Baltimore and Montgomery County. Office managers completed a brief compliance survey during the meeting designed to identify gaps in meeting the requirements.
- Presented on the transaction standards to medical offices affiliated with Doctors Community Hospital. About 80 people attended the presentation.
- Worked with Peninsula Regional Medical Center to develop a privacy education program for its nursing staff.
- Reviewed the transaction standard requirements with Franklin Square and Maryland General's information technology staff.

Institutional Review Board

The IRB met via conference call on June 4th with seven members participating. The agenda was to finalize the recommendations for a limited data set for releasing DC Hospital Discharge Data without IRB approval

PERFORMANCE & BENEFITS

Benefits and Analysis

Comprehensive Standard Health Benefit Plan (CSHBP)

At the November 2002 meeting, the Commission approved the proposed regulations to implement one change to the CSHBP, previously voted on at the October 2002 meeting: coverage for residential crisis services. The proposed regulations were published in the *Maryland Register* on January 24th. The comment period ended on February 24th. No public comments were received. At the March 2003 meeting, the Commission approved the regulations. This change will be implemented effective July 1, 2003.

On January 31st, Commission staff mailed survey packets to all carriers participating in the small group market in Maryland to collect their annual financial data. The deadline for carriers to submit these data was April 4th. All carriers responded in a timely manner. Our consulting actuary is in the process of auditing several carrier submissions. Staff has analyzed the survey results, including number of lives covered, number of employer groups purchasing the CSHBP,

loss ratios, average premiums as they relate to the statutorily-set affordability cap, etc. As a result of the enactment of Chapter 93 of the Laws of Maryland 2003 (SB 477), the Commission now is responsible for evaluating the cost of the CSHBP based on a 10-percent affordability cap. Staff will present this report later in today's meeting. This year's analysis is based on the newly established 10-percent cap, with historical data also included using a 12-percent cap. As a result of this study, Commission staff will review any proposed changes to the CSHBP and will present staff recommendations to the Commission at the September meeting. Mercer will present its evaluation of proposed benefit changes and the two-year projection of costs and wages at the September meeting also. Then, public hearings will be held in late September, followed by a presentation of the annual review of the CSHBP at either the October or November meetings.

Another provision of this new law requires the Commission, in consultation with the MIA, to perform an analysis and make recommendations on the administrative expenses in the small group market including the amount and distribution of administrative costs, strategies for lowering these costs, and the appropriateness of the medical loss ratios. This report is due by January 1, 2004. In addition, by December 1, 2003, the Commission must prepare a report outlining the methodology used by the Commission in developing the CSHBP, and the feasibility of creating a "Basic Plan" in addition to the CSHBP.

Commission staff has developed a website to be used as a guide for small business owners in their search for health insurance for their employees. This "Guide to Purchasing Health Insurance for Small Employers" is available on the Commission's website at: www.mhcc.state.md.us/smgrpmt/index.htm. Commission staff is in the process of developing a bookmark describing information available on the small group website. This bookmark will be presented to the Commission in the summer.

Evaluation of Mandated Health Insurance Services

At the November 2002 meeting, Mercer presented its evaluation of mandated health insurance services as to their fiscal, medical and social impact, along with all proposed mandates that failed during the 2002 General Assembly session to the Commission for release for public comment. At the December 2002 meeting, the Commission approved the report for release to the legislature, after some modifications to the Executive Summary. The final report was sent to the General Assembly in January 2003, and is available on the Commission's website at: www.mhcc.state.md.us/cshbp/mandates/finalmercerreport02.pdf.

The 2003 General Assembly passed HB 605, "Evaluation of Mandated Health Insurance Services." As a result, § 15-1502 of the Insurance Article was repealed; therefore, the Commission is no longer responsible for conducting a full review of each existing mandate if the 2.2-percent affordability cap is met. However, § 15-1501 remains in effect, which requires the Commission to assess the fiscal, medical, and social impact of any mandates proposed by the 2003 General Assembly. Additionally, HB 605 requires the Commission to evaluate all existing mandates every four years, in terms of the following: (1) an assessment of the full cost of each existing mandate as a percentage of Maryland's average annual wage, as a percentage of individual premiums, and as a percentage of group premiums; (2) an assessment of the degree to which an existing mandate is covered by self-insured plans; and (3) a comparison of Maryland mandates to those provided in Delaware, the District of Columbia, Pennsylvania, and Virginia based on number of mandates, type of mandate, the level and extent of coverage for each mandate, and the financial impact of differences in level of coverage for each mandate. The first of these reports is due to the legislature by January 1, 2004.

Maryland Health Insurance Plan (MHIP)

In 2002, the General Assembly enacted and the Governor signed HB 1228 under which the SAAC program and the Short-Term Prescription Drug Subsidy Program will be replaced with the Maryland Health Insurance Plan Fund and Senior Prescription Drug Program. Both will be administered by the newly created Maryland Health Insurance Plan (MHIP), an independent agency within the MIA. The Executive Director of the MHCC is a member of the Board. The MHIP Fund is financed through a proportionate assessment on hospital net patient revenue that would equal the CY 2002 SAAC funding. The new program is required to be operational on July 1, 2003, and hospitals began paying the assessment as of April 1, 2003 in order to fund the start-up. The MHIP Board is responsible for running the programs.

The MHIP Board has selected Maryland Physicians Care (MPC) as the MHIP contract administrator. As contract administrator, MPC will review applications from potential members, collect premiums, and pay health insurance claims for MHIP. MPC is owned by four Maryland community health systems: Maryland General Health Systems in Baltimore, Washington County Health System in Hagerstown, Western Maryland Health System in Cumberland, and St. Agnes HealthCare in Baltimore.

Carriers must report to the MIA the number of applications for medically underwritten individual policies that they have declined. The Senior Prescription Drug Program is funded through enrollee premiums and a subsidy by a nonprofit health service plan (CareFirst) not to exceed its premium tax exemption. The MHCC is no longer responsible for developing the benefit plan. The MIA required CareFirst (Maryland and D.C.) to have the last SAAC open enrollment in December 2002. CareFirst complied by advertising the open enrollment period in local newspapers throughout the month of December 2002.

The 2003 General Assembly passed HB 1100, allowing Bethlehem Steel retirees between the ages of 55 and 64 who do not yet qualify for Medicare to be able to enroll in MHIP beginning July 1st.

Legislative and Special Projects

Uninsured Project

In July 2002, DHMH, in collaboration with MHCC and the Johns Hopkins School of Public Health, was awarded a \$1.2 million State Planning Grant by the Health Resources and Services Administration (HRSA). HRSA is the federal agency that oversees programs to ensure access to care and improve quality of care for vulnerable populations. The one-year federal grant provides Maryland with substantial resources to examine the state's uninsured population and employer-based insurance market and to develop new models to make comprehensive health insurance coverage fully accessible to all Maryland residents.

Among the several activities, the one year grant will enable DHMH and MHCC to conduct further analysis of existing quantitative data sources (Maryland Health Insurance Coverage Survey, MEPS-IC, and CPS), as well as collect additional data that will help us design more effective expansion options for specific target groups. In addition, we have conducted focus groups with employers in order to better understand the characteristics of firms not currently participating in the state's small group market. For those firms currently participating in the CSHBP, issues were probed relating to costs of coverage and knowledge of the base CSHBP. In an effort to increase the take-up rate in the small group market, marketing materials were presented to the focus groups for review and modification. Shugoll Research was selected as the vendor to conduct these focus groups. The focus groups were completed on Friday, February 14,

2003, with over 70 employers and 20 brokers participating. A report summarizing the findings from the focus groups will be made available shortly.

A fourth meeting with the Health Care Coverage Workgroup was held on June 5, 2003. This group is comprised of members who represent the provider, business, health care advocacy, and health care research communities in the State. During the June meeting, additional information was presented on options pertaining to the small group and individual markets, and the options for 19 to 25 year olds. In addition, staff from DHMH, the MHCC, and the Johns Hopkins University presented data on Maryland's uninsured population, and preliminary findings from the cost of non-insurance study. The contractor for the MCHP Premium focus groups also presented preliminary findings. The next meeting with the Workgroup will be held in September.

The grant team was awarded a one-year, no cost extension of the project timeline, with an interim report due to the Secretary of the Department of Health and Human Services in July 2003 and the final report to be submitted in July 2004. The final report must outline an action plan to continue improving access to insurance coverage in Maryland.

Patient Safety

Chapter 318 (HB 1274) of 2001 requires the Commission, in consultation with DHMH, to study the feasibility of developing a system for reducing preventable adverse medical events. A Maryland Patient Safety Coalition was initiated by the Delmarva Foundation and served as the Commission's sounding board for its activities related to patient safety. Three workgroups were formed: one to look at issues related to systems changes to be recommended; one to address current regulatory oversight and reporting requirements; and a third to discuss issues related to a proposed Patient Safety Center.

A preliminary report, approved by the Commission at the December 2001 meeting, was sent to the General Assembly. One of the preliminary recommendations has been enacted by the General Assembly and signed by the Governor. That bill removes the medical review committee statute that applies to all health care practitioners from the BPQA statute, where it is currently codified, and places it in a separate subtitle within the Health Occupations Article to make practitioners more aware of the protections available to them. It also codifies case law to clarify that certain good faith communications designed to lead to remedial action are protected even when they are not made directly to a medical review committee or committee member, but are nevertheless designed to remedy a problem under the jurisdiction of a medical review committee. The final report has been approved by the members of the Commission and was submitted to the members of the Maryland General Assembly in January. Commission staff briefed two Legislative Committees—the House Health and Government Operations Committee and the Senate Education, Health, and Environmental Affairs Committee—on the study. A bill was introduced in the House to grant medical review committee status to the Maryland Patient Safety Center, as designated by the Commission. This bill will grant protections against legal liability and disclosure of information. It passed out of both Houses and was signed into law by the Governor.

The Maryland Patient Safety Steering Committee met in May to discuss the formulation of mission and vision statements for the Coalition, and the role of Maryland Patient Safety Coalition. It is anticipated that the Patient Safety Coalition will meet sometime during the summer.

In addition, Commission staff, along with the University of Maryland Office of Research and Development, LogiQ (a non-profit research entity affiliated with the Maryland Hospital Association) and the Delmarva Foundation recently submitted a proposal for a federal grant that would fund the creation of a Patient Safety Center. The grant proposal was submitted October 1, 2002.

Facility Quality and Performance

Nursing Home Report Card

Chapter 382 (SB 740) of 1999 requires the Commission, in consultation with the Department of Health and Mental Hygiene and the Department of Aging, to develop a system to comparatively evaluate the quality of care and performance of nursing facilities. The web-based Nursing Home Performance Evaluation Guide is available through the Commission's website. The Guide includes a Deficiency Information page, data from the Minimum Data Set (MDS) and the MHCC Long Term Survey, as well as an advanced search capability, allowing consumers to search by facility characteristics and certain services.

The Commission participated in the Centers for Medicare and Medicaid Services (CMS) pilot program with five other states from April through early November 2002. At the conclusion of the pilot, CMS conducted a national rollout of the CMS Nursing Home Quality Initiative on November 12, 2002. The Commission's website was subsequently updated in January 2003 to reflect the final CMS Nursing Home Quality measures. The website was also updated to include quality indicator data from January through June 2002. Seven of the 10 quality measures reported on the CMS website are featured on the Maryland Guide in the same format as the current Quality Indicators are, utilizing the symbols that separate the top 20%, bottom 10% and all others. CMS is reporting two new measures and one revised measure that are risk-adjusted using a Facility Adjustment Profile (FAP). Two of these measures are currently featured on the Guide without the FAP (Prevalence of Stage 1-4 pressure ulcers for chronic care and Failure to improve/manage delirium for post acute care) as recommended by the Hospital Report Card Steering Committee.

During March 2003, all facility deficiency information was updated reflecting survey information from the Office of Health Care Quality through December 2002. Consumers can also obtain historical information on nursing home deficiencies since January 2001.

Commission staff participated in the National Quality Forum's (NQF's) workshop to explore the revision of existing nursing home quality measures as well as the addition of new measures. A national call for measures is currently underway until the end of June.

Hospital Report Card

Chapter 657 (HB 705) of 1999 requires the Commission to develop a similar performance report on hospitals. The required progress report was forwarded to the General Assembly. The Commission also contracted with the Delmarva Foundation, in partnership with Abt Associates, to: (1) analyze hospital data to develop appropriate indicators for inclusion in the Hospital Performance Evaluation Guide, and (2) design and execute a consumer-oriented website for the Guide. The initial version of the Hospital Performance Evaluation Guide was unveiled on January 31, 2002.

A new edition of the Hospital Guide was released during a press conference held on May 16, 2003. The revised Guide includes quality of care information specific to the treatment and prevention of congestive heart failure and community acquired pneumonia including individual

hospital rates, the state average, and the highest rate achieved by a hospital for each of the measures. The first sets of conditions were selected from the Joint Commission on Accreditation of Healthcare Organization's (JCAHO's) ORYX initiative, which collects quality of care information from hospitals in a method designed to permit rigorous comparisons using standardized evidence-based measures.

The Hospital Guide continues to feature structural (descriptive) information and the frequency, risk-adjusted length-of-stay, and risk-adjusted readmissions rates for 33 high volume hospital procedures. DRG data was updated in December 2002 to include admissions occurring between December 1, 2000 and November 30, 2001.

MHCC staff fielded numerous telephone calls from the press, consumers, and providers following the release of the revised Guide. Future plans for the Guide include the addition of acute myocardial infarction (AMI) and obstetrical measures. A proposal to begin collection of these measures will be presented to the Commissioners at the June 19, 2003 meeting.

The Delmarva Foundation was awarded 'lead state' status to head a three-state hospital public reporting pilot project initiated by CMS. Delmarva will assist CMS with the following -

- Test the collection and reporting of the JCAHO/CMS performance measure sets;
- Test the AHRQ sponsored standardized patient experience (satisfaction) survey;
- Test additional performance measures as determined by the pilot states;
- Determine the least burdensome ways for hospitals to meet upcoming public reporting requirements;
- Determine how to integrate CMS mandated reporting with existing state level public reporting activities; and
- Determine how to best involve stakeholders in the development and execution of hospital public reporting activities.

The Hospital Report Card Steering Committee serves as the steering committee for the pilot and has been expanded to include additional rural, minority, payer, and business/employer representatives. The Committee serves as the primary vehicle for obtaining input and consensus prior to initiating the state specific activities.

Hospitals from the three states are currently participating in a patient satisfaction survey pilot. Information from this survey is confidential. The draft survey was developed by the Agency for Healthcare Research and Quality (AHRQ) and draws upon seven surveys submitted by vendors, a review of the literature, and earlier CAHPS work. The instrument is designed to evaluate the following eight domains:

- Respect for patients' values, preferences, and expressed needs;
- Coordination and integration of care;
- Information, communication, and education;
- Physical comfort;
- Emotional support;
- Involvement of family and friends;
- Continuity and transition; and
- Access to care.

The pilot instrument has 66 questions that require approximately 20 minutes to complete. It will be available in English and Spanish and includes questions designed to assess a patient's experience in the following areas:

- Care received from nurses;
- Care received from doctors;
- The hospital environment;
- The overall hospital experience;
- The admission process; and
- The discharge process.

The survey also collects some basic patient demographic information.

The survey was sent to a sample of patients that had an overnight stay, with the exception of pediatric and psychiatric admissions. The sample consists of 450 completed surveys from 20 core hospitals throughout the three states. The hospitals are stratified by size, teaching status, and geography. All other participating Maryland hospitals will have 50 completed surveys to provide them with some experience with the instrument.

The survey is being administered by mail with telephone administration to nonrespondents. CMS plans to conduct additional tests to determine if there are significant differences between mail and telephone respondents.

The pilot project began with a public call for measures in October 2002. The actual survey process began the first week of June 2003. It is anticipated that the survey will be conducted from June through July 2003 and analyzed in September 2003. The standard instrument and protocol for use is scheduled for finalization in September 2003.

Following completion of the pilot, the Maryland Hospital Report Card Steering Committee will evaluate the results of the study to determine if the instrument will meet the needs of Maryland consumers and to determine the best method of incorporating the data into the existing *Maryland Hospital Performance Evaluation Guide*. If the pilot is successful, Maryland residents will have another source of information with which to make important healthcare decisions.

In addition to the Pilot Project, a national coalition of healthcare organizations, including the American Hospital Association (AHA), the American Association of Medical Colleges (AAMC), the Federation of American Hospitals (FAH), the National Quality Forum (NQF) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), are participating in a voluntary initiative that will encourage every hospital in the country to collect and publicly report quality information.

The "starter set" of measures draws from three of JCAHO's Core Measure Sets: Acute Myocardial Infarction (AMI), Congestive Heart Failure (CHF) and Community-Acquired Pneumonia (CAP). Initially, Maryland hospitals will be able to report measures from just two of the areas (the CHF and CAP measures that are already being collected), but will be strongly encouraged to report from all three as soon as possible. This information, in addition to being on the MHCC website, will also be on CMS's website (www.medicare.gov) sometime this summer. The MHCC Hospital Performance Evaluation Steering Committee reviewed the draft website and provided comments to CMS.

Ambulatory Surgery Facility Report Card

Chapter 657 (HB 705) of 1999 also requires the Commission to develop a performance report for Ambulatory Surgery Facilities (ASFs). The Commission developed a web-based report that was also released on May 16, 2003. The website contains structural (descriptive) facility information including the jurisdiction, accreditation status, and the number and type of procedures performed in the past year. The site will also include several consumer resources.

An ASF Steering Committee was convened to guide the development of the report and will consist of representatives from a multi-specialty facility, a large single specialty facility, an office based facility, a hospital based facility, and a consumer representative. An exploratory meeting was held with a subset of this group in January 2003. Subsequently, the Steering Committee provided input on several of the proposed web pages including a consumer checklist, glossary, and list of resources.

HMO Quality and Performance

Distribution of 2002 HMO Publications

Cumulative distribution: Publications released 9/23/02	9/23/02- 5/31/03	
	Paper	Electronic Web
<i>The 2002 Consumer Guide to Maryland HMOs & POS Plans</i> (25,000 printed)	21,934	Interactive version 1,347 visitor sessions
<i>2002 Comprehensive Performance Report: Commercial HMOs & Their POS Plans in Maryland</i> (700 printed)	661	

2003 Policy Report (2002 Report Series) –
Released January 2003; distribution continues until January 2004

<i>Policy Report on Maryland Commercial HMOs & POS Plans</i> (1,200 printed)	1/16/03—5/31/03
	801

Distribution of 2002 Publications

Distribution challenges remain a focus of this Division. Though outgoing copies of the *Guide* increased during the month due to requests from Prince George's County Education Association and Harford County Department of Administration, generally requests during this year's spring open enrollment experienced a decline. McCormick Company has been a stalwart user of the *Guide* in past years, requesting hundreds of copies for employee distribution. The decision to discontinue paper distribution of this report was made. Employees of the company seeking qualitative information have been directed to the MHCC website through a notification included in their benefit packages.

Staff attended the spring meeting of the Maryland Health Care Coalition. The coalition is comprised of various sized employers committed to improving health care value through community health reform. Measuring the comparative quality and efficiency of hospitals, physicians, and health plans in the community to identify the best value serves as the guiding tenet of the group. The *Guide* was well received by attendees and further information will be sent out to the Coalition's members via its newsletter. Clearly, functions of this type facilitate community awareness of our report and promote the type of relationship building that past efforts in cultivating employer interest have lacked. Future outreach will include more direct contact of these types with decision-makers.

2003 Performance Reporting: CAHPS Survey and HEDIS Audit

MHCC staff reviewed, edited, and finalized the report template that will be used by audit vendor, HealthcareData.com (HDC), to provide a summary of key processes and plan results that comprise the HEDIS audit. Each plan will receive a copy of its own report, while MHCC and NCQA will receive the complete set of nine reports. The report allows a final evaluation of how effectively work done during the audit supports final designations issued by the auditor. Because HDC was the audit firm last year, the report will include a section describing any progress from the previous audit and note areas that require further improvement.

HMO Division staff has worked with HDC in making sure that medical record review and review of source code were completed on time. Both of those tasks are now finished. In preparation for report development, data transfer has been arranged. Last month MHCC, HDC, and the survey vendor participated in a conference call with the report development vendor who will produce the *Guide* and other MHCC publications. Both vendors agreed to provide their respective data files on the agreed upon dates. In addition, HDC will provide MHCC with a report of all measures, by plan, showing the final rates and report status of each measure by June 20th. The final phase of the HEDIS audit is nearing completion.

On May 23rd, Synovate submitted CAHPS survey results for the nine Maryland HMOs to the NCQA. Those results await validation by NCQA as that organization resolves system problems currently affecting calculation of summary files. All health plans will receive their summary and member-level data files once the results are validated. Synovate will also provide each plan with a final report displaying their individual results and Maryland average for each survey question. Division staff made several revisions in the instructions for final reports to health plans and MHCC. A key change includes the request for the survey vendor to identify factors and comment on their implication in causing a downward shift in overall response rate. For example, a preliminary review of the final disposition report indicates a possible trend among national plans. Also, several questions will be examined by product type (HMO, POS) and demographic characteristics.

Report Development Contract/Optional Unit Work

Report development started early in anticipation of bringing a new look to the *Guide*. Format and content changes were explored through a series of four focus groups conducted in May. Family Research Group moderated the groups. Because employers and consumers have unique perspectives on how they use the performance report, two groups of each met to test comprehensibility, value, and usability. Staff attended all sessions and quickly developed a synopsis of their preferences and criticisms to develop recommended changes.

Participants unanimously agreed on the value of providing comparative information on the performance of Maryland's HMOs. Though employers considered the information valuable, the

majority indicated they would not distribute the *Guide*. Reactions initially reflected concerns over backlash that may result if the company offered a plan that had inferior performance or even offered a choice of plans. In addition to this concern was the perception of employers that employees would have difficulty digesting and effectively using information presented in such a complex manner. Employer representatives considered New Mexico's brochure on consumer ratings of the state's largest HMOs (an example of a more condensed report) a format they would more likely distribute.

The lessons learned from the focus groups will be used in combination with knowledge gained through distribution activities to guide modifications made to the 2003 *Guide*.

HEALTH RESOURCES

Certificate of Need

During May 2003, staff issued on the Commission's behalf a total of three determinations on non-coverage. One of those determinations involved the acquisition of the Home Health Agency owned by Doctor's Community Hospital. This home health agency was purchased by Professional Healthcare Resources. The remaining two determinations of non-coverage by CON involved ambulatory surgery facilities. The Rotunda Ambulatory Surgery Center, located in Baltimore City, notified the Commission of a change in medical staff. The 33rd Street Surgery Center, LLC received a determination of non-coverage to establish an ambulatory surgery center with one operating room and three non-sterile procedure rooms located at 200 E. 33rd Street, in Baltimore City.

Acute and Ambulatory Care Services

Maryland's acute care bed licensure law, Health-General §19-307.2, requires annual recalculation of all acute care hospitals' average daily census, and application of a formula to assign each hospital its licensed acute care bed capacity for the next fiscal year. Every hospital's licensed bed capacity is equal to 140 percent of its average daily census for the most recent 12 month period available. When the new data is sent to the hospitals, the hospitals are required to complete an application form notifying the Commission and the Office of Health Care Quality how those beds will be designated among the individual services. The new bed licensure data and application forms were sent to all hospitals on May 19, 2003 for fiscal year 2004. The final licensed bed designation forms will be sent out in late June and will be effective July 1, 2003. The resulting licensed bed capacity serves as the single, official source of acute care hospital bed inventory for the state. A new item was added to the application form this year asking for the number of beds that can actually be set up and made available for patient care, independent of either current utilization or staffing issues. This information could assist the Department's understanding of actual current acute care capacity for emergency preparedness planning.

Staff established the Acute Care Hospital Planning Workgroup to discuss issues concerning the proposed revisions to the State Health Plan chapter on acute inpatient services, COMAR 10.24.10. A preliminary draft of the proposed SHP changes and proposed revisions to the acute care bed need projection methodology were both released for informal public comment in 2002. The fourth meeting of the workgroup was held on May 30, 2003. The agenda included a discussion of the draft Plan's project review standard regarding rules about rate increases for major capital expenditure projects, in response to written public comments. The agenda also

included a discussion of the results of staff's survey of daily fluctuations in hospital acute care census, conducted over two one-week periods in September of 2002 and March of 2003, and a discussion of revisions to the acute care bed need projections. The next meeting of the workgroup is tentatively scheduled for the second week in July, and will include a review of a revised draft of the SHP chapter.

On May 14, 2003 Pat Cameron served as an invited panelist for the Harford Leadership's health and healthcare session to discuss health care planning and regulation, and its impact on Harford County.

On June 8, 2003 several representatives of the health resources division staff met with Dr. Carlos Santos-Burgoa, Director General of Planning and Health Development in the Ministry of Health of Mexico, to describe the structure and functions of Maryland's health resources planning and certificate of need programs. Dr. Santos is currently leading the effort of Mexico's Secretariat of Health to develop health initiatives required by the new health reforms in Mexico.

Long Term Care and Mental Health Services

Staff of the Long Term Care division further revised and refined the *2001 Report on Maryland Nursing Home Occupancy Rates and Nursing Home Utilization by Payment Source*. This report summarizes data on the occupancy levels and utilization of licensed comprehensive care facilities and extended care facilities in Maryland, by facility, jurisdiction, and region. There is also an analysis of trends in these data from 1996 to 2001. This report will be presented to the Commission at the June 19th meeting.

On May 21, 2003, staff attended a conference sponsored by the Georgetown University Long Term Care Financing Project entitled "The 21st Century Challenge: Providing and Paying for Long-Term Care". Following opening remarks by Judy Feder and Sheila Burke, Co-Directors of the Long Term Care Financing Project, there was a presentation by Judy Woodruff, CNN anchor, regarding the challenges faced by a mother of a son with serious disability. This was followed by a panel of persons who face disability, either themselves or as family members. Issues of financing and gaps in financing were recurrent themes. The next panel included Chad Boulton, Johns Hopkins Lipitz Center for Integrated Health; Catherine Hawes, Texas A&M; William Kiernan, Institute for Community Inclusion; and Robyn Stone, Institute for the Future of Aging Services. This panel dealt with "blue sky" (as they described it) suggestions on how to address systemic issues. The afternoon featured a more federal perspective with addresses by Senator David Durenberger; Bill Scanlon of the GAO; Julie James of Health Policy Alternatives; Chip Kahn of the Federation of American Hospitals; Stephen McConnell of the Alzheimer's Association; Carol Raphael of the VNA of New York; and Ray Scheppach of the National Governors Association. The conference ended with Tom Scully presenting his perspective from CMS.

Staff of the Long Term Care Unit reviewed the contract that Myers and Stauffer has had since January 2003 to assist the Commission in entering data from the Minimum Data Set (MDS) into a database and adapting the Commission's previous work with data from its Long Term Care Survey to the MDS variables. Staff has reviewed the work done to date and has renewed the contract for a second year. The second year of the contract will focus on data refinement and updates, and also on the development of, and revisions to, the nursing home bed need methodology.

Staff also issued an additional Bid Board Notice to use the MDS to provide updated data programming and analysis support to produce summary tabulations analyzing data from the MDS for Maryland nursing homes. Such data support will be used to update the Long Term Care Chart book and to respond to data requests in the long term care area. This contract was awarded to Myers and Stauffer for a period from June 2003 through November 2003 with the option of future renewals.

At the April meeting, the Commission released for informal public comment proposed modifications to COMAR 10.24.01. Comments were due to the Commission by May 22, 2003. A summary and analysis of these comments has been prepared and will be presented at the June Commission meeting.

Specialized Health Care Services

After reviewing and discussing the revised draft recommendations at a meeting on May 28th, the Inter-Hospital Transport Subcommittee of the Advisory Committee on Outcome Assessment in Cardiovascular Care finalized its recommendations to the Steering Committee. The subcommittee also heard a presentation by Richard L. Alcorta, M.D., State Medical Director, Maryland Institute for Emergency Medical Services Systems (MIEMSS), regarding the MIEMSS Specialty Care Transport Regulations.

At its meeting on June 2nd, the Steering Committee of the Advisory Committee on Outcome Assessment in Cardiovascular Care reviewed and approved, with additions, the Final Report of the Interventional Cardiology Subcommittee. The committee also heard reports from the Long Term Issues, Quality Measurement and Data Reporting, and Inter-Hospital Transport subcommittees. At the Commission's public meeting on June 19th, Commission staff will present the recommendations of the Steering Committee regarding interventional cardiology.

Staff's presentation of the Statistical Brief on Organ Transplant Services and the Projected Utilization and Need for New Organ Transplant Programs for Target Year 2005 was postponed for one month, until June 19th. The brief is available at:

<http://www.mhcc.state.md.us/resources/reports/specializedhlthcare/statisticalbrief.pdf>.

The projections were published in the *Maryland Register* on May 30th.

The June 5th meeting of the Work Group on Rehabilitation Data was postponed because corrected data for the first quarter of 2003 were not available for all acute inpatient rehabilitation facilities. The meeting has been rescheduled for Thursday, June 26, 2003, at 1:00 p.m. in Room 100 at 4160 Patterson Avenue, Baltimore, Maryland 21215.